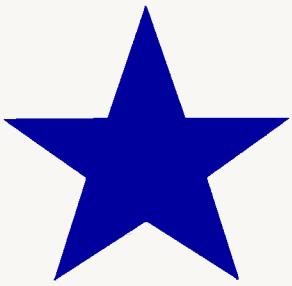
A Guidebook for

VHA Medical Facility Integration



Department of Veterans Affairs

A Guidebook for

VHA Medical Facility Integration

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Veterans Health Administration
U.S. Department of Veterans Affairs
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Chapter 1 - Overview

In recent years, hundreds of U.S. hospitals have merged, consolidated or otherwise pooled their assets and operations to create larger entities providing more integrated services. Despite the large number of such actions in the private sector, no single formula, process or template for such efforts has yet emerged. This is not surprising in view of the many forces and variables that bear on such strategies (Table 1.1).

Table 1.1
Illustrative Forces and Factors Affecting Healthcare Facility Integration Strategies

Driving Forces

- Quality improvement
- Market conditions
- Changing patient population
- Access
- Excess capacity
- Technological change
- Capital

Specific Factors Affecting Integration Strategy

- Size of the catchment area
- Healthcare needs of the population served
- Geography of catchment area
- Population density
- Proximity of facilities
- Array, level and overlap of services
- Referral patterns
- Community resources
- Organizational cultures
- Stakeholder views*
- Facility capacities

* See Table 1.2

Over the past three years, the Veterans Health Administration (VHA) has combined the assets and operations of 44 facilities to create 21 local integrated healthcare systems (Table 1.3, pages 5-7 and Table 1.4, pages 8-9). The integrations of these medical facilities have been part of the larger network integration strategy initiated in 1995. This strategy is aimed at providing more accessible, more reliable, and more consistently high quality health care.

While VHAhas provided general, and in some cases specific, guidance for such efforts, networks (Veterans Integrated Service Networks or VISNs) and facilities have been given considerable flexibility in how such integrations have been accomplished because of the recognized variability in circumstances and needs that such efforts have addressed. It has also been recognized that flexibility encourages and supports innovation and organizational learning. VHA Headquarters continues to recognize these needs; however, VHA's substantial experience to date also suggests that a more uniform or consistent process could benefit future facility integration efforts. For example, a more uniform process might facilitate procedural understanding for and accountability to VHA's myriad stakeholders, yet not compromise needed flexibility at the network and facility levels as long as the process is not rigid or overly prescriptive.

This Guidebook is intended to assist networks and facilities that are considering integrations. It delineates a generic five-phase integration process and identifies critical elements and key events in each phase.

Integration, Consolidation or Merger?

VHA has used the term "integration" to describe the pooling of assets and operations of facilities, although such actions also have been variously referred to as mergers or consolidations. These latter terms may be more applicable in the private sector where such actions have most often involved facilities having different ownership. VHA recognizes that the best term to describe these actions could be argued from various perspectives according to nuances of language, and that there is no one specific best term. VHA has opted to use integration because the involved facilities are all part of the same healthcare system that serves a well-defined and relatively stable population. In fact, in some cases, the involved facilities have historically served much the same subpopulation.

VHA believes the specific terminology used to characterize the process is less important than the underlying concept. The strategic intent of pooling resources is to create synergies that enable VHA to provide easily accessible, high quality care for as many patients as possible with its available resources. (In this regard, resources are taken broadly to include employees, buildings and other physical plant assets, equipment, clinical and management support, funds, etc.)

The essential aspect of facility integration is that two or more facilities, and generally their various clinical and support operations (e.g., laboratories, acquisition and materiel management, and fiscal services), are combined under single management. The integration seeks to pool resources to better meet the healthcare needs of the populations that were formerly served by the

separate facilities. The resources previously used to support duplicative administrative infrastructure or redundant clinical services are redirected to enhance quality, access or other clinical needs. In doing so, beneficiaries' healthcare needs should be better served.

Why VHA Medical Facility Integration?

The overriding strategic intent of facility integrations is to create better ways of serving veterans with VHA's limited resources. More specifically, facility integrations are intended to achieve six purposes:

1. Increase the predictability and consistency of having a full array of high quality healthcare services;
2. Increase access to care;
3. Optimize the utilization of physical plant, equipment, personnel and other resources;
4. Modernize VA healthcare, from the perspectives of both physical plant and other capital assets, as well as administrative practices and clinical processes;
5. Increase the cost-effectiveness of operations; and
6. Provide opportunities for adding services or modalities of care by redirecting resources.

In this regard, it is important to reiterate that facility integrations are part of a larger strategy to develop integrated delivery systems that facilitate the pooling and alignment of resources to best serve patients. The development of integrated delivery systems that will provide more coordinated and more comprehensive care is the basic strategy behind creation of the VISNs. Facility integrations are merely the same concept applied on a smaller scale at the local level.

What Drives a Successful Facility Integration?

Early, open and continuous communication with stakeholders (Table 1.2) is key to the success of the facility integration process. Continual communication helps to address the myriad questions that will arise from stakeholders. It will also help alleviate the uncertainty and inevitable fear that always accompanies change. Such feelings are normal and should be anticipated in facility integrations.

Table 1.2 VHA Stakeholders

- Veteran patients and their families
- VA employees and their unions
- Veterans service organizations at the national, state and local levels
- State veterans homes
- Academic and other facility affiliations
- Department of Defense and other sharing partners
- Congress/federal elected officials
- State and local elected officials
- Other operating units of the Department of Veterans Affairs
- Internal VHA management
- Local community
- Other

It is essential that excellent communication lines be established, both internally and externally, from the beginning. It is equally important that they be constantly maintained in order to keep all stakeholders apprised of integration activities and the rationale for those activities.

Further, in pursuing facility integrations, it is essential that these actions be considered in the context of the relevant VISN strategic plan, and that both be understood to be evolutionary - that is, both the facility integration plan and the VISN strategic plan must be adaptive and responsive to:

- Changes in the local private and public healthcare milieu,
- Changes in VA healthcare and other federal healthcare programs (e.g., Medicare and Medicaid),
- New network-wide and system-wide strategies, and
- Changes in the myriad other specific circumstances and factors that bear on these plans (Table 1.1).

Table 1.3
Approved VHA Integrated Facilities

VA Black Hills Health Care System:
VAMC Ft. Meade, SD
VAMC Hot Springs, SD
113 Comanche Road
Fort Meade, SD 57741
Voice - (605) 347-2511
Fax - (605) 347-7171

Approval Date: 5/21/96

VA Central Alabama Veterans HC System:
VAMC Montgomery, AL
VAMC Tuskegee, AL
2400 Hospital Road
Tuskegee, AL 36083-5001
Voice - (334) 727-0550
Fax - (334) 724-2793

Approval Date: 9/10/96

VA Central Iowa Health Care System:
VAMC Des Moines, IA
VAMC Knoxville, IA
3600 30th Street
Des Moines, IA 50310-5774
Voice - (515) 699-5999
Fax - (515) 699-5862

Approval Date: 12/3/96

VA Central Texas Health Care System:
VAMC Marlin, TX
VAMC Temple, TX
VAMC Waco, TX
1901 South First Street
Temple, TX 76504
Voice - (254) 778-4811
Fax - (254) 771-4563

Approval Date: 3/21/95

VA Chicago Health Care System:
VAMC Chicago (Lakeside), IL
VAMC Chicago (West Side), IL
333 East Huron Street
Chicago, IL 60611
Voice - (312) 943-6600
Fax - (312) 640-2248

Approval Date: 6/27/96

VA Connecticut Health Care System:
VAMC Newington, CT
VAMC West Haven, CT
950 Campbell Avenue
West Haven, CT 06516
Voice - (203) 932-5711
Fax - (203) 937-3868

Approval Date: 3/21/95

VA Eastern Kansas Health Care System:
VAMC Leavenworth, KS
VAMC Topeka, KS
2200 Gage Boulevard
Topeka, KS 66622
Voice - (785) 350-3111
Fax - (785) 350-4309

Approval Date: 7/9/97

VA Greater Nebraska Health Care System:
VAMC Grand Island, NE
VAMC Lincoln, NE
600 South 70th Street
Lincoln, NE 68510
Voice - (402) 489-3802
Fax - (402) 486-7849

Approval Date: 4/21/97

Table 1.3 *(continued)*
Approved VHA Integrated Facilities

VA Hudson Valley Health Care System:
VAMC Castle Point, NY
VAH Montrose, NY
Route 91, P.O. Box 100
Montrose, NY 10548
Voice - (914) 737-1216
Fax - (914) 737-8127

Approval Date: 4/9/97

VA Maryland Health Care System:
VAMC Baltimore, MD
VAMC Ft. Howard, MD
VAMC Perry Point, MD
10 North Greene Street
Baltimore, MD 21201
Voice - (410) 605-7000
Fax - (410) 605-7900

Approval Date: 3/21/95

VA New Jersey Health Care System:
VAMC East Orange, NJ
VAMC Lyons, NJ
385 Tremont Avenue
East Orange, NJ 07018
Voice - (973) 676-1000
Fax - (973) 676-4226

Approval Date: 5/21/96

VA North Florida/South Georgia Health Care System:
VAMC Gainesville, FL
VAMC Lake City, FL
1601 South West Archer Road
Gainesville, Florida 32608
Voice - (352) 376-1611
Fax - (352) 374-6113

Approval Date: 10/1/97

VA North Texas Health Care System:
VAMC Bonham, TX
VAMC Dallas, TX
4500 South Lancaster Road
Dallas, TX 75216
Voice - (214) 376-5451
Fax - (214) 372-7943

Approval Date: 11/12/96

VA Northern Indiana Health Care System:
VAMC Ft. Wayne, IN
VAMC Marion, IN
2121 Lake Avenue
Fort Wayne, IN 46805
Voice - (219) 426-5431
Fax - (219) 460-1410

Approval Date: 3/21/95

VA Palo Alto Health Care System:
VAMC Livermore, CA
VAMC Palo Alto, CA
3801 Miranda Avenue
Palo Alto, CA 94304
Voice - (650) 493-5000
Fax - (650) 852-3228

Approval Date: 1/4/95

VA Pittsburgh Health Care System:
VAMC Pittsburgh (Highland Drive), PA
VAMC Pittsburgh (University Drive), PA
University Drive "C"
Pittsburgh, PA 15240
Voice - (412) 688-6000
Fax - (412) 784-3941

Approval Date: 5/21/96

Table 1.3 *(continued)*
Approved VHA Integrated Facilities

VA Puget Sound Health Care System:
VAMC American Lake, WA
VAMC Seattle, WA
1660 South Colombian Way
Seattle, WA 98108
Voice - (206) 762-1010
Fax - (206) 764-2250

Approval Date: 3/21/95

VA South Texas Veterans Health Care System:
VAMC Kerrville, TX
VAH San Antonio, TX
7400 Merton Minter Boulevard
San Antonio, TX 78284
Voice - (210) 617-5300
Fax - (210) 617-5167

Approval Date: 9/10/96

VA Southern California System of Clinics
VAMC Sepulveda, CA
Los Angeles OPC
16111 Plummer Street
Sepulveda, CA 91343
Voice - (818) 891-7711
Fax - (818) 895-9559

Approval Date: 11/14/96

VA Western New York Health Care System:
VAMC Batavia, NY
VAMC Buffalo, NY
3495 Bailey Avenue
Buffalo, NY 14215
Voice - (716) 862-3611
Fax - (716) 862-3679

Approval Date: 3/21/95

VA Health Care System: (name pending)
VA Eastern Montana Health Care System
VAM&ROC Fort Harrison, MT
Highway 12 & Williams Street
Ft. Harrison, MT
Voice - (406) 442-6410
Fax - (406) 447-7923

Approval Date 3/9/98

Table 1.4

Characteristics of Integrated Facilities (Pre-Integration)

	SIZE			Nature of Service				Level of Service		Demography				Degree of Academic Affiliation		
	SMALL	MEDIUM	LARGE	ACUTE	PSYCH	EXTENDED/DOM CARE	HBPC PROGRAM*	TERTIARY	NON-TERTIARY	A	B	C	D	LIMITED	INTERMEDIATE	TERTIARY
VA Black Hills Health Care System HCS																
Ft. Meade		X		X	X	X			X	X				X		
Hot Springs		X		X		X			X	X				X		
VA Central Alabama Veterans HCS																
Montgomery	X			X					X			X		X		
Tuskegee			X	X	X	X			X	X				X		
VA Central Iowa HCS																
Des Moines		X		X			X		X			X			X	
Knoxville			X		X	X			X	X				X		
VA Central Texas HCS																
Marlin	X			X		X			X	X				X		
Temple			X	X		X		X			X				X	
Waco			X		X	X			X			X		X		
VA Chicago HCS																
Lakeside		X		X				X					X			X
West Side		X		X				X					X			X
VA Connecticut HCS																
Newington	X			X			X		X		X				X	
West Haven			X	X			X	X			X					X
VA Eastern Kansas HCS																
Leavenworth		X				X			X		X			X		
Topeka			X		X				X			X		X		
VA Greater Nebraska HCS																
Grand Island	X			X		X			X		X			X		
Lincoln	X			X					X			X		X		
VA Hudson Valley HCS																
Castle Point	X			X			X		X	X				X		
Montrose			X		X	X			X	X				X		
VA Maryland HCS																
Baltimore			X	X			X	X					X			X
Ft. Howard	X					X			X	X				X		
Perry Point			X		X	X			X	X				X		

Definitions:

SIZE (total beds): small = <100; medium = 100 to 400; large = >400 beds

DEMOGRAPHY (city population): A < 25,000; B = 25,000 to 100,000; C = 100,000 to 250,000; D > 250,000

DEGREE OF ACADEMIC AFFILIATIONS (AY 95/96): limited = <20 residents; Intermediate = 20-69 residents; tertiary = >70 residents

***Home-Based Primary Care**

****Sharing**

Table 1.4 *(continued)*

Characteristics of Integrated Facilities (Pre-Integration)

	SIZE			Nature of Service				Level of Service		Demography				Degree of Academic Affiliation		
	SMALL	MEDIUM	LARGE	ACUTE	PSYCH	EXTENDED/DOM CARE	HBPC PROGRAM*	TERTIARY	NON-TERTIARY	A	B	C	D	LIMITED	INTERMEDIATE	TERTIARY
VA New Jersey HCS																
East Orange			X	X		X	X	X			X					X
Lyons			X		X	X			X	X				X		
VA North Florida/South Georgia HCS																
Gainesville		X		X	X	X	X	X				X				X
Lake City		X		X	X	X	X		X		X			X		
VA North Texas HCS																
Bonham		X		X		X			X	X				X		
Dallas			X	X			X	X					X			X
VA Northern Indiana HCS																
Ft. Wayne	X			X			X		X			X		X		
Marion			X		X	X			X		X			X		
VA Palo Alto HCS																
Livermore		X		X		X			X		X			X		
Palo Alto			X	X	X	X	X	X			X					X
VA Pittsburgh HCS																
Highland Drive			X		X				X				X	X		
University Drive			X	X		X	X	X					X			X
VA Puget Sound HCS																
American Lake		X			X	X			X			X		X		
Seattle			X	X				X					X			X
VA South Texas HCS																
Kerrville		X		X		X			X	X				X		
San Antonio			X	X				X					X			X
VA Southern California System of Clinics																
Sepulveda			X	X	X	X		X					X			X
LAOPC			X						X				X	X		
VA Western New York HCS																
Batavia	X			X		X			X	X				X		
Buffalo			X	X				X					X			X
VA Health Care System (name pending)																
Eastern Montana HCS	X			X**		X			X	X				X		
Fort Harrison	X			X	X				X		X			X		

Definitions:

SIZE (total beds): small = <100; medium = 100 to 400; large = >400 beds

DEMOGRAPHY (city population): A < 25,000; B = 25,000 to 100,000; C = 100,000 to 250,000; D > 250,000

DEGREE OF ACADEMIC AFFILIATIONS (AY 95/96): limited = <20 residents; Intermediate = 20-69 residents; tertiary = >70 residents

***Home-Based Primary Care**

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Chapter 2 - The Five Phases of Facility Integration

In 1996, following its first few facility integrations, VHA prepared a handbook, *Perspectives on Facility Integration*, to share information on the successes and problems that had been encountered up to that point. With subsequent integrations, VHA has refined the integration process. At this point, based on the system's collective experience, VHA has identified a five-phase strategic planning approach to facility integration. The five phases are:

- Phase I - Visualization and Conceptualization
- Phase II - Analysis and Decision-Making
- Phase III - Planning
- Phase IV - Implementation
- Phase V - Evaluation

These phases are explained in more detail in the following sections. The specific components in each phase or their sequence may vary depending on local and network circumstances. Some components may overlap into more than one phase. The components, as listed in each phase, are not intended to prescribe a certain sequence or priority. Likewise, the listed components are not intended to be inclusive of all issues or aspects attendant to every integration. Almost every integration entails factors unique to the involved facilities.

Phase I - Visualization and Conceptualization

Critical Elements:

- Communication
- Organizational assessment
- Environmental assessment

The first phase of any reorganization effort requires determining the organization's need for and willingness to change. External forces often drive this need for change. Phase I is characterized by assessing both the internal and external environments.

The Chief Network Officer (10N) must be notified of the intent to engage in preliminary discussions of integration activities prior to involvement of internal and external stakeholders (Appendix A). This is necessary to ensure Headquarters officials are aware of a potential facility integration.

In Phase I, network and facility management should conceptualize the organization's future function and structure. For this purpose, it is appropriate to think at least 2-3 years into the future, and possibly five years, although most experts would agree that there is too much uncertainty in today's healthcare environment to do five-year planning.

In this conceptual phase of integration, it is imperative to review all options for any new organizational structure. There are many organizational design options available to management: intra- and inter-facility service consolidations, inter-facility integrations with or without mission changes, and facility or campus closure, among others.

Organizational leadership is the key to providing vision for the integration, but it also requires the input of others. Even at this early stage, communication with stakeholders is critical. The adequacy of this communication will have long-lasting effects.

This phase concludes with a decision either to not proceed further or to move forward to Phase II.

Key Events:

1. Notify Chief Network Officer of intent to explore the possibility of an integration

2. Internally explore and discuss possible integration:

   Establish work groups
   Designate a steering committee
   Search the relevant literature
   Seek staff input

3. Communicate with stakeholders about the idea

4. Specify the reasons for and delineate the criteria to be utilized for evaluating the potential integration:

   Establish goals and objectives for the potential integration
   Set criteria for decision-making regarding the potential integration
   Define or delineate customer needs and availability of services
   Describe potential impacts - clinical, economic, political, etc.
   Specify potential patient care or other uses of savings and efficiencies achieved

Phase II - Analysis and Decision-Making

Critical Elements:

- Communication
  - Discussion of service delivery options
  - Briefing of internal and external stakeholders
  - Input from internal and external stakeholders
- Refinement and further definition of integration goals and objectives
- Identification of an integration organizational leader
- Assignment of responsibility for oversight of integration (coordinator/committee/council)
- Development of planning timeline
- Cost-benefit analysis
- Decision-making

This phase is characterized by the collection and evaluation of data regarding the potential reorganization effort. These two separate but linked steps are the keys to strategic planning. It is important to determine and validate all data and facts as they are presented for consideration. Input from all interested stakeholders is important to facilitate understanding and buy-in during this decision-making phase. Throughout Phase II, it is very important to offer opportunities for staff input into the potential changes. All staff affected by the changes must be made aware of the purposes and potential advantages of the integration.

The decision-making process must be clearly defined. While it may not always be evident from the initial data analysis which direction the organization should pursue, it is important to recognize that prolonged uncertainty about the decision increases organizational stress and probably lowers staff morale. There may not be buy-in from all stakeholders, since some may feel that the integration is not in their own personal best interest. Thus, the decision should be based on the overall benefit to veterans and taxpayers, rather than individual stakeholders.

Based upon information gathered in Phase I and the analysis done in Phase II, organizational leaders decide whether to pursue the restructuring, alter the plan, or abandon it altogether. If the decision is to proceed with the integration, the next step is to develop and submit a formal proposal for the integration to the Chief Network Officer in VHA Headquarters. The components to be included in the integration are to be found in Table 2.1.

Phase II concludes when the integration proposal is approved by the Secretary of the Department of Veterans Affairs.

Table 2.1
Components of the integration proposal to be submitted to VA Headquarters

- Names and locations of the facilities to be integrated
- A description of the facility missions, with details about workload, etc.
- The rationale for the integration
- A description of how the proposed integration will relate to the VISN strategic plan, including the specific integration goals and objectives
- Alternative integration scenarios
- Documentation of stakeholder and staff communication and involvement
- The communication plan
- A description of the evaluative measures to be used throughout the integration process
- A description of both existing and proposed organizational structures
- A description of the planned integration process
- A description of current facility characteristics that includes, but is not limited to:
    - Clinical service inventories
    - Patient service areas
    - Referral patterns
    - Budget
    - Workload statistics
    - Physical plant capabilities and needs
- Identification of human resource issues and management processes, including any potential need to reduce full-time equivalents (FTE) and how that would be done.

Key Events:

1. Perform a detailed analysis of the economic, administrative and clinical impacts of integrating services. This should include, at a minimum:
    - Determine service location and market penetration through market analysis
    - Analyze impact on access, timeliness, customer satisfaction, and cost of care
    - Conduct strengths, weaknesses, opportunities and threats analysis
    - Compare pre-integration versus post-integration FTE levels

2. Involve stakeholders repeatedly to solicit and respond to their concerns and issues:
    - Frequent communication
    - Use multiple methods of internal and external communication; e.g., town hall meetings, briefings, newsletters, patient mailings, focus groups, press releases (Appendix C), etc.
    - Involve all employees, especially clinical staff, in these discussions

3. Convene work groups:
    - Establish the operating rules for the functional work groups
    - Issue charge letter that defines scope, parameters and assumptions
    - Designate point of contact to respond to questions from work groups
    - Establish/augment work groups, including various internal and external stakeholders to address:
        - Patient care services
        - Facility database integration
        - Human Resource Management issues
            - FTE requirements of the new organization
            - Selection criteria development
        - Financial issues
        - Crosstraining and continuing education
        - Capital assets
        - Community relationships

4. Begin development of the integration evaluation plan
    - Involve stakeholders
    - Develop evaluation criteria and instruments

5. Consider other management actions:
    - Recruit and select director of integrated facility
    - Assign responsibility for oversight of the integration process
        - Establish integration coordinator position and/or integration coordination council/committee
    - Determine whether to utilize consultants
    - Ensure stakeholder representation on steering committee
    - Develop integration timeline
    - Seek expert assistance in helping staff cope with change (e.g., overcoming fears and resentments associated with change or reassignments)

6. Submit formal integration proposal to VHA Headquarters (Table 2.1)

Phase III - Planning

Critical Elements:

- Communication
  - Approval of integration
  - Brief stakeholders and especially focus on communication with staff affected by the change
- Development of new mission and vision statements
- Establishment of a single set of medical staff bylaws
- Description of the new organizational structure
- Recruitment and selection of key management officials
  - Preliminary consolidation of some services/functions
  - Designation of service chiefs/service line managers
- Identification of options for service location and mix
- Integration of databases
- Humanization of integration processes
- Development of integration implementation plan
- Development of infrastructure to foster multi-site meetings via audio or video teleconferencing
- Development of corporate identity for integrated facility

The Planning Phase follows the Secretary's approval of the proposed integration. It is characterized by defining the proposed structure and functions of the new organization. A critical component in defining the organization's structure and functions is to match care and services with veteran need and demand.

An essential element of Phase III is the establishment of a single set of medical staff bylaws.

Phase III includes the development of new mission and vision statements that will help define the emerging organization. These guiding principles facilitate the formulation of specific goals and objectives, assessment and scenario-planning.

Active stakeholder involvement in the development of these guiding principles is critical. Management, in conjunction with stakeholders, evaluates whether the integration initiative will meet the goals and objectives. Throughout this phase, management must utilize focused quality management principles to communicate the integration plan to all stakeholders, especially staff and labor partners. This phase ends when a clear, detailed implementation plan has been outlined, reviewed and refined with input from stakeholders.

Options to determine service location and mix should be developed. The coordination of patient care is a key determinant in resolving questions about the level of care to provide and where care should be offered. Once final determination is made, the infrastructure to support service location and mix should be planned. The new organizational structure should allow the seamless transfer

of patients between sites. It is important that the new organization's infrastructure accommodate multi-site meetings - e.g., audio or video teleconferencing.

Infrastructure modifications should be prioritized based on:

1. Impact on quality of and access to care
2. Customer satisfaction
3. Defined timelines
4. Cost-benefit analysis
5. Other compelling reasons

It is important to request a facility name change and a single station number immediately following proposal approval (Appendix B). The established naming convention (Department of Veterans Affairs, the geographic location, Health Care System) will symbolically reflect the new identity and interdependence of the integrated facility. The new identity will need to be publicized to all customers. Signage or other physical evidence of the new entity should be widely evident.

The station number will enable the facility to accurately document fiscal and workload activities. Planning the merger of the facilities' databases is another important facet of Phase III. Integrated sites will have one VistA system that users will access for administrative and clinical activities.

The humanistic aspects of the integration process must be emphasized in this phase and should be remembered throughout the process. Particular attention should be paid to employees losing position and title. Counseling, crosstraining, advancement opportunities and similar support should be "advertised" and made readily available to staff.

Key Events:

1. Delineate and specify tasks required to integrate the facilities:
   - Develop the integration implementation plan
   - Develop mission and vision statements
   - Request single facility number and name
   - Use new facility name in signage, patient and public information, and correspondence
   - Plan database merger
   - Clearly define management team and management structure
   - Ensure senior management and service chiefs are visible at all locations and available to stakeholders
   - Establish single set of medical staff bylaws
   - Standardize staff salaries

- Develop plans for staff retraining and crosstraining
  - Use quality improvement information and data to determine staff education and training needs
  - Match staff competencies with realigned positions
- Develop plans for excess capacity and underutilized assets
- Develop and review capital improvement plan(s), including previously approved and still viable construction projects with requirements prioritized
- Enhance infrastructure and processes
  - Telecommunication/conferencing capabilities
  - Transportation
  - Transfer coordination
- Provide opportunities for staff counseling, especially for displaced employees
- Develop communication tools for veterans and families regarding changes that will directly affect them (Appendix D)

2. Evaluation and analysis of integration alternatives and selection of the best approach:
   - Evaluate service location and mix
     - Options for providing services
       - Capacity for general/acute care
       - Access to special emphasis programs
       - Capacity and needs for long-term care
       - Resource sharing agreements
       - Contracting out
     - Impact on patients and their families
     - Relocation of staff
   - Link integration plan with VISN strategic plan
   - Link integration plan to performance measures
   - Benchmark outcomes

3. Present completed integration implementation plan and timeline to stakeholders

4. Adjust implementation plan and timeline according to stakeholder feedback

5. Ensure frequent and meaningful bi-directional communication with staff

Phase IV - Implementation

Critical Elements:

- Communication
  - Notification of patients and families regarding changes in service
  - Stakeholder briefings
  - Ongoing dialogue with stakeholders
- Implemention of standardized business practices and standards of care
- Consolidation of performance improvement programs

Implementation of the integration plan sets in motion a clear operational commitment. Reorganizing existing resources according to the implementation plan should result in enhanced patient care, including higher quality of care, better access, improved customer service and efficiencies. Although all stakeholders are deemed important in the integration process, it is critical to include the representative labor union(s) and the Partnership Council in the implementation phase. The need for frequent and meaningful communication with staff and their representatives cannot be over-emphasized.

Integrating clinical and administrative services and standardizing business practices should result in significant economies of scale. Savings gained from economies of scale should be used to enhance quality of and access to care. It is important that staff understand that this process is directed at improving patient care and patient outcomes.

As the delivery and the potential location of healthcare changes, new communication strategies will be needed. Information about relocated services, enhanced transportation systems or changing facility mission(s) must be relayed to all stakeholders, especially staff, veteran patients and their families (Appendix D).

An important part of this phase also includes the consolidation of performance improvement programs. Functions of quality management, utilization review and patient safety/risk management must be uniformly coordinated. Performance improvement programs impact the organization's accreditation process and link to the Performance Measurement System. The facility should document the integration process in a way that demonstrates its effect on performance, and especially quality of and access to care.

Key Events :

1. Implementation of common management and administrative functions:
   - Involve stakeholders in implementation
     - Notify patients and their families of changes that impact their care
     - Involve labor/management partnership
     - Provide repeated opportunities for discussion with staff
   - Fully integrate telecommunication

- Consolidate policies, directives, and instructional memoranda
- Merge databases
- Standardize business practices
- Realign staff to address workload shifts
- Provide crosstraining opportunities
- Continue to explore strategies to maximize organizational efficiencies and quality improvement opportunities
- Consolidate services and functions - local or network
- Develop service lines - local or network

2. Integrate clinical and administrative services:
   - Integrate clinical activities along natural referral patterns
   - Evaluate need to relocate services to meet demand, if economically feasible
     - Establish primary care at all locations
     - Explore strategies to enhance access, e.g., Community Based Outpatient Clinic (CBOC)
     - Redirect inpatient resource savings to support ambulatory care
   - Consolidate and finalize joint medical staff bylaws
   - Review credentialing and privileging functions and activities

3. Communicate with stakeholders

4. Amend or modify plans, as needed

Phase V - Evaluation

Critical Elements:

- Communication
  Stakeholder briefings and discussion
  Focus groups
- Evaluation of achievement of outcome measures, goals and objectives
- Re-evaluation of actions
- Dissemination of best practices and lessons learned

In this phase, the organization evaluates the clinical and administrative processes and outcomes resulting from the integration. The organization must measure the effect of the integration based on predetermined goals and specific performance assessment criteria. It is important to plan well in advance to develop evaluative tools that measure critical factors. VHA uses several relevant indicators including timeliness, access, quality of care measures (e.g., surgical outcomes, complication rates) and customer satisfaction that allow internal and external benchmarking. These outcome-based measures should provide quantitative and/or qualitative feedback concerning the effectiveness of strategic decisions. The data obtained in this phase become the basis for course corrections and future strategic planning.

Stakeholders must be involved in determining the outcomes of integration. This feedback recognizes the contributions that stakeholders made to the integration process and helps to enhance the importance of their continued support and participation. Negative outcomes should be addressed and made the basis for further modifications.

It is important to organizationally acknowledge loss of the identity of the prior organizations and the sense of loss that some persons may experience as a result. This is a natural human response, and acknowledging it can facilitate employee acceptance of the change process. Celebrate successes, no matter how small. Celebrations provide opportunities for the organization to reward the efforts of all those involved in the process.

Evaluation provides the necessary evidence base to determine whether the organizational changes were effective in better meeting the needs of those whom VA serves.

Key Events:

1. Establish evaluation team that includes stakeholders

2. Refine evaluation methodology and evaluation instruments

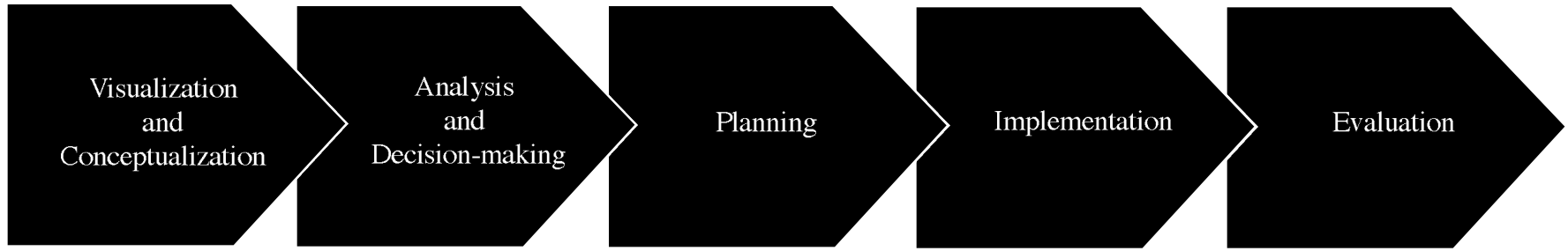
3. Analyze achievement of the integration's stated goals:
    Indicators to be evaluated include:
        Access
        Timeliness
        Customer and employee satisfaction
        Cost/price
        Other outcome measures established as part of the Performance Measurement System
    Assess achievement of integration goals, including:
        Improved patient outcomes
        Improved timeliness/access
        Standardized care
        Decreased unnecessary service and personnel redundancies
        Maintained viability of the facilities' missions
        Assessment of unexpected/untoward outcomes
        Provision of full array of services

4. Identify other outcomes of the integration
    Process-related outcomes

5. Further amend or modify plans, as needed

6. Communicate with stakeholders

Schematic of the Five-Phase Integration Process



Communication

Independent Medical Facilities

Integrated Health Care Facilities

Critical Elements of Integration Phases

Visualization and Conceptualization	Analysis and Decision-making	Planning	Implementation	Evaluation
Assess organization	Refine & define goals & objectives.	Develop mission and vision	Implement standardized business practices	Evaluate achievement of outcome measures, goals & objectives
Assess environment	Identify integration organizational leader	Establish medical staff bylaws	Implement standards of care	Re-evaluate actions
	Assign responsibility for integration oversight	Describe organizational structure	Consolidate performance improvement programs	Disseminate best practices & lessons learned
	Develop planning timeline	Select key management officials		
	Analyze cost-benefit	Identify options for service location & mix		
	Make decision about integrating	Integrate databases		
		Humanize integration process		
		Develop integration implementation plan		
		Develop infrastructure to foster multi-site meetings		
		Develop corporate identity for the integrated facility		

Key Events of Integration Phases

Visualization and Conceptualization	Analysis and Decision-making	Planning	Implementation	Evaluation
Notify Chief Network Officer of intent to explore possibility of integration	Perform detailed analysis of economic, administrative & clinical impacts of integration activities	Delineate & specify tasks required to integrate the facilities	Implement common management & administrative functions	Establish evaluation team including stakeholders
Explore & discuss integration internally	Actively & repeatedly involve stakeholders to address their concerns	Evaluate & analyze integration alternatives & select the best approach	Integrate clinical & administrative services	Refine evaluation methodology & evaluation instruments
Specify reasons for & delineate criteria for evaluating the potential integration	Convene work groups	Present completed integration implementation plan to stakeholders	Amend or modify plans as needed	Analyze achievement of the integration's goals
	Begin to develop integration evaluation plan	Adjust implementation plan & timeline according to stakeholder feedback		Identify other outcomes of the integration
	Consider other management actions	Ensure frequent dialogue with staff		Further amend or modify plans
	Submit integration proposal to VHA Headquarters			

Chapter 3 - Conclusion

Integrating the management and operation of individual medical facilities has proven to be a valuable tool in restructuring healthcare processes and in establishing integrated service networks. Such actions require considerable organizational change. Change is always difficult, and lessons are inevitably learned with experience.

The important role of stakeholders and communication with stakeholders cannot be over-emphasized. Stakeholders must be involved at every step of the process, from the beginning conceptualization through the final evaluation. Careful planning that involves all organizational elements is critical to the success of the integration effort.

Additional VHA facility integrations are planned, and these actions are likely to be rigorously scrutinized. As such, VHA will undoubtedly receive suggestions and recommendations on how to further improve our facility integration process. As new and additional information becomes available, VHA must adjust accordingly. There are many different forces and factors affecting an integration and no perfect formula, process or template has yet emerged. VHA's integration process has improved with experience, and we will continue to learn as the process evolves.

So far, facility integrations have strengthened the veterans healthcare system by increasing access, improving quality of care, optimizing resource utilization and increasing efficiency of operations. Quite simply, integrations have helped the veterans healthcare system do a better job of serving veterans and their families.

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APPENDIX A
Medical Facility Integration
Notification/Approval Process

The notification process begins with a memo from the Network Director to the Chief Network Officer (CNO) (10N). This memo documents plans to explore potential integration of two or more VISN facilities. Notification must occur prior to discussions with any external stakeholder to ensure Headquarters is aware of the situation and can respond appropriately when stakeholders inquire. The CNO will discuss this notification with the Under Secretary for Health. Once the CNO has acknowledged notification to explore possible integration, the VISN can begin planning and discussion of options.

The integration planning process must include all internal and external stakeholders. When the integration planning process has been completed and the details of the proposed integration have been discussed with and communicated to all internal and external stakeholders, the VISN should request official approval of the integration.

To receive approval, the Network Director should submit an integration proposal to the CNO (10N/10NA). Upon receipt of the integration proposal, the CNO will review the information, follow up with any questions and forward the approval request to the Under Secretary for Health.

Once support for the integration has been given by the Under Secretary for Health, the integration proposal will be forwarded to the Secretary for final approval. Approval by the Secretary is necessary prior to making any official announcements.

The CNO will inform the Network Director of the decision regarding integration approval. The Facility Director will be responsible for notifying local stakeholders according to the documented communication plan. The CNO will work with the Secretary's office to ensure that the appropriate offices in Headquarters (i.e., Congressional Affairs, Voluntary Services, Public Affairs, Labor Management Relations) are informed.

The approved plan will be shared with stakeholders along with a letter to be signed by the Network Director. This letter will also describe plans for upcoming briefings on the newly approved integration, work groups (which will be established to begin planning for integration) and a point of contact at the VISN or facility should questions/concerns arise. A press release (Appendix C) announcing the integration will also be included. The press release will be prepared by VA Headquarters Public Affairs in conjunction with the Office of the Under Secretary for Health.

APPENDIX B

FACILITY NAME CHANGE POLICY

PURPOSE: Provide general guidance to facility management on changing the name of a medical facility.

BACKGROUND: Policies and procedures for assigning uniform station numbers to all VA facilities and naming/renaming VA facilities are set forth in MP-1, Part II, Chapter 34, "VA Uniform Station Numbering."

There is no reference in this policy that stipulates a facility must include the words "Veterans Affairs" in its name, or that it must be named after its geographical location. However, it does state that "...facilities are generally named after the geographical location where they are situated."

For consistency purposes, the words "Veterans Affairs" should remain in the title, and the integrated facilities should be called a "health care system."

PROCEDURE: Follow these procedures when submitting a request for a facility name change:

1. The Medical Center Director (00) will submit a memorandum requesting approval of a facility name change to the Under Secretary for Health (10) through the respective Network Director (10N_) and the Chief Network Officer (10N).

2. The name requested must include the following words in the prescribed sequence:

    - the "Department of Veterans Affairs" (VA)

    - the "geographic" location

    - "Health Care System"

3. The request should include a brief statement of justification for the name change.

In addition to the memorandum requesting approval of a facility name change, the Medical Center Director will also submit a memorandum from the Under Secretary for Health (10) to the Office of the Assistant Secretary for Management (004) for notification of the name change. A sample is provided in this policy.

February 1998

APPENDIX B *(continued)*
Sample Memorandum to Request Facility Name Change

Department of Veterans Affairs

Memorandum

Date:

From: Under Secretary for Health (10NA)

Subj: Facility Name Change _____and_____ VAMCs

To: Office of the Assistant Secretary for Management (004)

1. On (Date) the Secretary of Veterans Affairs approved the request for merger of the _____and_____VA Medical Centers submitted by the Network Director (10N___). The Director of the merged medical centers now requests a name change for the combined facilities as follows:

Department of Veterans Affairs (VA) _____Health Care System

2. A separate request will be submitted to the Director of Information Management Service (045A4) for a change in station number.

3. The name change should be effective immediately. If there are any questions please contact (Name HSS in 10NA) at (202) 273-5846.

Kenneth W. Kizer, M.D., M.P.H.

Attachment (i.e., request from facility director/Network)

APPENDIX B *(continued)*
Sample Memorandum to Request Facility Number Change

Department of Veterans Affairs

Memorandum

Date:

From: Medical Center Director, VAMC _____

Subj: Request for Change of Station Number

To: Director, Information Management Service (045A4)
Thru: Chief Network Officer (10N)

1. On (Date) the Secretary of Veterans Affairs approved the request for the integration of the_____and_____VA Medical Centers submitted by the Network Director (10N___). As Director of integrated facilities, I am requesting a change in station number.

2. Current divisions and station numbers are:

DIVISION	CURRENT STATION NUMBER
ABC Medical Center	123
XYZ Medical Center	012
CBOC	123GA

The lead facility will be the _____ VA Medical Center.

3. If you have any questions regarding this request, please contact (Name) at (Phone).

MEDICAL CENTER DIRECTOR

cc: 105

APPENDIX C
Sample News Release

Office of Public Affairs
News Services

Washington, D.C. 20420
(202) 273-5700

Department of Veterans Affairs

News Release

SEPULVEDA VA MEDICAL CENTER L.A. AREA CLINICS TO MERGE

Washington, November 22, 1996 - The Department of Veterans Affairs (VA) is announcing the integration of management and operations of its Sepulveda Medical Center and Los Angeles Outpatient Clinic into the VA Southern California System of Clinics. The merger also includes the Bakersfield and Santa Barbara Outpatient Clinics.

A potential merger of the Sepulveda VA Medical Center with the Los Angeles Outpatient Clinic has been under discussion for several years, but was accelerated by the January, 1994 earthquake which destroyed inpatient buildings at Sepulveda and resulted in the change of mission to a primarily ambulatory care facility.

Said Under Secretary for Health Dr. Kenneth W. Kizer, "Within the last two years, we have successfully merged many other VA facilities. The increased emphasis by health-care providers nationwide on providing integrated ambulatory and primary care services has resulted in greater access, better quality of care, improved customer satisfaction and reduced administrative costs by eliminating duplication. Any savings derived are used to improve direct care for patients."

The merger will consolidate clinical services, education, research and administrative services, resulting in increased efficiency and reduced costs. Maintenance and patient transportation also will be consolidated. A common data base of patient records will be established. The four outpatient clinics have an existing referral pattern for patients who require hospitalization, referring them to VA medical centers in the greater Los Angeles area.

Discussions about the integration have been underway since March of this year with a wide variety of groups that will be affected, including veterans service organizations, congressional representatives, union representatives and employees at all four facilities. These discussions will continue as the merger moves forward.

The integration follows the successful merger of 26 VA medical centers at 12 other locations throughout the United States.

Management at each location where facilities have merged develop evaluation and monitoring plans to measure patient satisfaction, the amount of resources redirected to patient care, expansion of patient services, waiting times for appointments and quality assurance issues.

APPENDIX D
Sample Stakeholder Letter

To be modified consistent with local situation

Subject: Open letter to veterans and the community

I have received many calls and letters from veterans who are concerned about the future of the ABC VA Medical Center. It is my sincere hope that this communication will help dispel rumors and assist you in understanding what changes are being proposed for the medical center.

A proposal to integrate the ABC and XYZ VA Medical Centers has been submitted to the Secretary of Veterans Affairs for approval. The goal for this integration is to merge the management structure of the two facilities. I have enclosed an information sheet with some questions and answers related to the integration of the ABC and XYZ facilities. I hope you find it helpful.

(Insert a paragraph describing some of the specific issues relevant to the specific proposal.)

I am committed to your service and welcome your comments. If you have any questions, please call (Name) at (Phone).

Sincerely,

Director

Enclosure

APPENDIX D *(continued)*

QUESTIONS AND ANSWERS ON INTEGRATING THE ABC AND XYZ VA MEDICAL CENTERS

Q: What does it mean to integrate the ABC and XYZ VA Medical Centers?

A: The proposal to integrate means combining management and administrative support functions of the two medical centers. It would mean one budget, one management team. Departments will be combined in order to gain efficiencies and reduce duplication of administrative functions. For example, there may be one manager for Medical Administration, Nursing, Social Work, Pharmacy, etc. We would combine administrative services and integrate certain functions such as payroll, time-keeping, acquisition and materiel management and personnel. By combining resources the two medical centers will be in a better position to provide healthcare to more veterans to improve quality and maintain affordability. The more money we can redirect to patient care, the more veterans we can serve.

Q: Will integration of the two medical centers mean the ABC VA Medical Center will be closed?

A: No. VA is committed to improving accessibility and quality of services for veterans. However, we must provide service cost effectively. For example, we must ask ourselves, "Is it cost effective to keep a 24 hour acute care unit open with less than ten patients?" To answer this question, we must consider other nearby VA facilities and potential community partners. We can serve more veterans if we reduce costs while maintaining quality and access.

Q: Why is the integration important to veterans served by ABC and XYZ?

A: Integration would put VA in a better position to maintain service and improve quality to veterans currently receiving VA healthcare. By integrating the two medical centers immediate savings would be realized in salary dollars and administrative overhead. Savings will be redirected into patient care.

Q: Will veterans be part of the decision-making process?

A: Yes. As the ABC and XYZ VA Medical Centers approached the idea of integration, management at both Medical Centers have met regularly with veterans, employees, members of Congress or their staff, County Service Officers, and the State Director of Veterans Affairs. These meetings and discussions will continue. Veterans are encouraged to serve on committees, ask questions and provide feedback.

Q: When will these two facilities be integrated?

A: Once the approval to integrate is received, there will be work groups formed to determine what, where and how services will be provided at each facility. The work groups will consist of staff, veterans and other stakeholders who have a knowledge of what is needed. Within three months of the approval, the working groups should be able to give us an outline of what each facility will look like. The outline will frame the implementation plan.

Q: What are the goals of integration?

A: VA's goal for integration is to reduce overhead and redirect savings into patient care. We plan to develop sharing agreements with local healthcare providers, redesign services to better meet the patients' needs, improve access, reduce waiting times, enhance transportation and improve patient satisfaction.

Q: Whom do I call if I have questions?

A: If you need more information call, (Name) at (Phone Number). Written requests for information should be mailed to: (Address).

APPENDIX E

STATEMENT OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON VA'S TREATMENT FACILITY INTEGRATION STRATEGY
BEFORE THE
SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS'AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JULY 24, 1997

STATEMENT OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON VA'S TREATMENT FACILITY INTEGRATION STRATEGY
BEFORE THE
SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JULY 24, 1997

I am pleased to be here today to discuss with the Subcommittees one particular strategy that VHA is utilizing to better serve its patients. This is our treatment facility integrations strategy.

In these opening comments I would like to briefly do two things. First, I would like to provide some context for these integration efforts and for some of the more facility specific comments that will be made by other witnesses on this panel. Second, I would like to quickly overview the generic process being utilized to implement this strategy.

As you know, revolutionary forces are buffeting the entire American healthcare system. These forces are causing profound changes in private sector healthcare, as well as in government programs, and they necessitate the creation of new types of delivery organizations. The delivery model being pursued most widely, for a number of reasons, is the integrated service network (ISN) — also known as an integrated delivery system (IDS) — in which organizational entities like hospitals and clinics, partner with physicians and other caregivers, as well as healthcare support functions, in creative ways to pool their resources and align them to better serve patient needs. These ISNs are taking many forms and are developing in different ways in response to the myriad antecedent conditions and specific circumstances driving their creation.

In the veterans healthcare system, hospital and other facility integrations, as well as clinical and support service integrations, are part of the larger network integration strategy aimed at providing more accessible, reliable and consistently high quality care for as many patients as possible with the resources available.

More specifically, the five generic purposes of this strategy that apply to the 40 facilities that have, so far, been approved for integration are:

To increase access to care;

To increase the predictability and consistency of high quality care being provided;

To optimize the utilization of physical plant and capital assets, personnel and other resources (i.e., to better capitalize on the strengths of each facility);

To modernize VA healthcare - its administrative practices, clinical and care management strategies, and physical assets; and

To reduce unnecessary costs and increase the efficiency of operations (and especially to free up dollars spent on administration for direct patient care).

In considering these generic purposes it is important to also consider several other contextual points. For example, as noted above, facility integrations are part of a larger network integration strategy. Facility integrations do not necessarily produce a lasting end product, but instead are part of an ongoing integrative process that may involve circumstances and changes beyond the specific facilities involved. For example, the merger of the radiology services at two integrating hospitals may be superseded by a network-wide teleradiology initiative. Similarly, the consolidation of the food service or laundry operations at two integrating facilities may be superseded by a network-wide bulk food preparation initiative or consolidation of all network laundry activities at a yet different facility. Unfortunately, the disparate circumstances prevalent at facilities and within the networks mean that these various activities are evolving from differing starting points and at different paces.

A second point of context is that no single formula or process has yet been devised that works for these integrations because of the varying nature of the involved facilities (i.e., rural-urban-suburban location, small-larger size, general acute care-psychiatric-extended care mission, tertiary-non-tertiary care), the different specific services they provide and the particular issues being addressed by the integration, among other things. Every one of our 19 integrations so far has involved a different set of facility characteristics.

Treatment facility integrations are all different because they address different issues and circumstances. Indeed, despite the hundreds of hospital mergers and integrations that have occurred in the private sector, there is not yet an agreed upon integration process or template in the private sector. To quote from an article in the May 1997 issue of Healthcare Leadership Review, “There is no ‘right’way to integrate.” The article goes on to say that, “It isn’t possible to develop a model that anticipates changes in the marketplace. Integrated delivery systems (IDSs) need to explicitly acknowledge and plan for change as markets develop and participants adapt and grow.” An article in the July/August 1997 issue of Healthcare Forum Journal further makes this point with its title, “One size doesn’t fit all … The right way to integrate.” It is generally not possible to describe all of the long-term outcomes of facility integrations since the integrated facilities and their delivery systems are living entities that will continue to change and evolve over time as they

address their unique mix of clinical, demographic, geographic, social, economic and cultural issues.

Another important contextual point to be made is that VA has committed to having a high degree of stakeholder involvement and participation in the decision-making process regarding clinical service integration. If we are going to honor this commitment, which Congress has generally supported, then we cannot have determined all the outcomes before stakeholders have a chance to work through the issues with VA. Quite simply, we cannot have an open and participatory process and have predetermined outcomes. If stakeholders are going to be meaningfully involved in decision making then VA cannot have already made the decisions prior to involving them in the process.

To date, VA Headquarters has approved integration of the management of 40 medical treatment facilities (19 integrated facilities). Of course, each integration is at a different phase of reorganizing since the approvals have occurred at different times over the last two years. So far, these facility integrations have produced efficiencies estimated at well over $50 million; we expect this amount to significantly increase in the future. Over 1,000 FTE have been reduced as a result of the integrations. While administrative FTE has been decreased, the facilities have been able to add clinical staff. Even in times of limited budgets, the facilities have increased primary and specialty care. Clinics have been opened or enhanced at facilities that historically referred patients to more distant facilities, resulting in improved access and reduced waiting times. In addition, resources generated from these efficiencies have been used to open Community Based Outpatient Clinics, replace much needed medical equipment, and make necessary facility capital improvements.

In developing plans for and in implementing facility integrations, network directors collaborate widely with leadership and stakeholders. The need to do this has been repeatedly reaffirmed. Further, VHA Headquarters has tried to provide guidance to field facilities to assist the process. For example, in the spring of 1995, authority and guidance was issued to the field granting individual medical centers the flexibility to respond to changing local and regional circumstances in the healthcare marketplace. Organizational changes that add, eliminate, or consolidate clinical and support services at facilities are subject to review and approval by the Network Director. However, proposals to integrate entire treatment facilities under a single management structure are reviewed and approved by VA Headquarters. Information submitted for review includes, for example, a statement on the missions and geographical service areas of the facilities affected, patient referral patterns, historical background, significant milestones, stakeholder involvement, current issues, goals, and evaluation plan.

I want to emphasize the important role of our stakeholders in this change process and assure you of our intent to involve stakeholders from the beginning of the process to final evaluations. Our stakeholders include veterans service organizations, Congressional members and staff, academic affiliates, the community, labor-management partnership councils/unions, and employees. With stakeholders' help most of the integrations and consolidations have proceeded without significant

difficulties or incident. Indeed, at integrations involving only 4 of the 40 facilities pursuing integration have notable problems developed.

As we all know, change is not easy, and lessons are inevitably learned with experience. As such, VHA has tried to learn from its experience and refine the integration process over time. In May 1996, VHA prepared a 'lessons learned' book to share information on successes and problems encountered on the integrations that were then underway. And now, after an additional year of experience, we are preparing a more current guidebook based on a much larger number of facility integrations. This publication will better identify and define the general phases and many steps of the integration process. I want to stress, however, that it is not my intent to be unnecessarily prescriptive or to formulate a rigid bureaucratic process that stifles creativity and innovation. However, with the experience that we now have we can more clearly define a process that should help guide VISNs and facilities through this process. Indeed, based on our experience to date, there appears to be 5 phases to the integration process. These phases are as follows:

Phase I - Visualization, Conceptualization and Initial Exploration

The internal exploration and discussion of the possible integration, initial communication with stakeholders about the idea, and delineation and specification of the reasons and criteria for integration.

Phase II - Quantitative and Qualitative Analysis and Decision Making

Completing a detailed analysis of the economic, administrative and clinical impacts of integrating services, initiating active stakeholder involvement to understand their concerns and issues, and convening planning committees, as needed, if the decision is made to proceed with the integration.

Phase III - Implementation Planning

The specification of the tasks required to integrate the facilities, evaluation and analysis of alternative integration scenarios, and selection of the best approach.

Phase IV - Implementation of Integration Plan

The integration of common management and administrative functions, successive integration of clinical and clinical support services, and course corrections, as needed.

Phase V - Evaluation

Monitoring results of the integration, analysis of whether the integration's stated goals were achieved, identifying other results and outcomes of the integration, and further course corrections, as needed.

With respect to evaluation, I have also requested that our Health Services Research and Development Service, through its Management Decision and Research Center, to conduct a systematic assessment and evaluation of all of our medical facility integrations. The study is currently in progress and, at present, is focusing on treatment facilities approved for integration between January 1995 and September 1996, plus the Southern California System of Clinics.

Mr. Chairman, in summary, integrating medical treatment facilities, as well as individual services or functions, has proven to be a valuable tool for VISN Directors in restructuring and establishing integrated service networks. This strategy and its implementation has produced understandable anxiety and resistance from some of our stakeholders. The one concern expressed most often has been that the integration was a precursor to closure of one of the facilities when, in fact, it was being done to improve the viability of both facilities. Indeed, as a result of these integrations, the VHA has been able to treat more veterans, make VA care more accessible, reduce administrative costs, expand services, and achieve many other positive results in light of our severe fiscal constraints. We are continually trying to improve the integration process and, thus, we welcome suggestions from GAO, the private sector, or others on how best to accomplish this strategy.

That concludes my statement. I will be happy to answer your questions.

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